

City of Nashua Division of Public Health and Community Services Asthma Education and Outreach Program



Release and Exchange of Confidential Information

I hereby authorize an exchange of information regarding my child's demographics, health insurance status, and doctor, as well as any important medical information regarding my child's asthma between the Nashua Health Department and:

Lamprey Healthcare	☐ Dartmouth-Hitchcock Health		☐ Nashua Pedia]					
Name of Provider Making this Referral: Phone: Fax: Address: (Please Print) Patient Name [Last, First, Middle] Date of Birth M/F Parent / Guardian Name [Last, First, Middle] Street Address City Apt # Zip Code Home Phone Number () Best day(s) and time(s) to call you: M am / pm T am / pm W am / pm TR am / pm F am / pm School Your Child Attends School Nurse Grade Primary Language Spoken at Home? English Spanish Arabic Bosnian Other: Health Insurance Status Primary Care Provider YES; Type: NO Health Insurance NO Primary Care Provider I further authorize the City of Nashua, Division of Public Health and Community Services Asthraction and Outreach Program. I further authorize the City of Nashua, Division of Public Health and Community Services Asthraction and Outreach Program. I further authorize the City of Nashua, Division of Public Health and Community Services Asthraction and Outreach Program. I also understand that a representative from the Asthma Education and Outreach Program will be contacting me directly to official enroll my child in this program. I also understand that a representative from the Asthma Education and Outreach Program mill be contacting me directly to official enroll my child in this program. I also understand that a representative from the Asthma Education and Outreach Program mill be contacting me directly to official enroll my child in this program. I also understand that a representative from the Asthma Education and Outreach Program mill be contacting me directly to official enroll my child in this program. I also understand that a representative from the Asthma Education and Outreach Program mill be contacting this agreement for further asthraces management. I understand this release may be revoked at any time with a written request. I understand I may request a cop of this signed release. This authorization is in effect for 1 year from date of signing.					Specify Other:					
Phone: Fax:	☐ Nashua Health	☐ St. Joseph Health				-				
Phone: Fax:	Name of Provider Making this Ref	erral·								
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FAX or MAIL this Form and Other Pertinent Information to:

Please mail all correspondence to:

City of Nashua Division of Public Health and Community Services 18 Mulberry Street, Nashua, NH 03060

Please fax or call Public Health Nurses:

Community Health Department Fax: (603) 594-3323 Phone: (603) 589-4500